Solicitation Information
June 26, 2013

RFI# 7477366

TITLE: Emergency Room Diversion

Submission Deadline: July 31, 2013 @ 10:00 AM (EST)

Questions concerning this solicitation must be received by the Division of Purchases at David.Francis@Purchasing.ri.gov no later than **July 9, 2013 @ 10:00 AM (EST).** Questions should be submitted in a *Microsoft Word attachment.* Please reference the RFP# on all correspondence. Questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

SURETY REQUIRED: No

BOND REQUIRED: No

David J. Francis

Interdepartmental Project Manager

Applicants must register on-line at the State Purchasing Website at www.purchasing. ri .gov

Note to Applicants:

Offers received without the entire completed four-page RIVIP Generated Bidder Certification Form attached may result in disqualification.

THIS PAGE IS NOT A BIDDER CERTIFICATION FORM

Table of Contents

1. INTRODUCTION

The Rhode Island Department of Administration/Division of Purchases, on behalf of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is soliciting information from community agencies to describe how they would approach the development and implementation of a three-year pilot of a Sobering Treatment Opportunity Program *(STOP). STOP* would serve chronic alcohol-dependent individuals who are intoxicated without emergent medical conditions who can be safely diverted from hospital emergency rooms in the City of Providence because they do not have emergency medical conditions.

This is a Request for Information (RFI). No award will be made as a result of this solicitation.

1.1 INSTRUCTIONS AND NOTIFICATIONS TO OFFERORS:

1. Potential vendors are advised to review all sections of this RFI carefully and to follow instructions completely, as failure to make a complete submission as described elsewhere herein may result in rejection of the proposal.

2. The State invites feedback from the community on any questions posed in this RFI. Please note it is not a requirement to answer all questions.

3. Alternative approaches and/or methodologies to accomplish the desired or intended results of this RFI are solicited.

4. This is a Request for Information (RFI), and as such no award will be made as a result of this solicitation.

5. All costs associated with developing or submitting responses to this RFI, or to provide oral or written clarification of its content shall be borne by the vendor. The State assumes no responsibility for any costs.

6. Responses misdirected to other state locations, or which are otherwise not present in the Division at the time of opening for any cause will be determined to be late and may not be considered. For the purposes of this requirement, the official time and date shall be that of the time clock in the reception area of the Division.

7. Respondents are advised that all materials submitted to the State for consideration in response to this RFI will not be considered to be Public Records as defined in Title 38, Chapter 2 of the General Laws of Rhode Island. The responses may only be released for inspection upon RFI once an award of a subsequent procurement has been made, as long as the release will not place the State at a competitive disadvantage in its sole discretion.

8. Interested parties are instructed to peruse the Division of Purchases website on a regular basis, as additional information relating to this solicitation may be released in the form of an addendum to this RFI.

9. Equal Employment Opportunity (G.L. 1956 § 28-5.1-1, et seq.) – § 28-5.1-1 Declaration of policy – (a) Equal opportunity and affirmative action toward its achievement is the policy of all units of Rhode Island state government, including all public and quasi-public agencies, commissions, boards and authorities, and in the classified, unclassified, and non-classified services of state employment. This policy applies to all areas where State dollars are spent, in employment, public services, grants and financial assistance, and in state licensing and regulation. For further information, contact the Rhode Island Equal Opportunity Office at (401) 222-3090.

10. In accordance with Title 7, Chapter 1.2 of the General Laws of Rhode Island, no foreign corporation, a corporation without a Rhode Island business address, shall have the right to transact business in the State until it shall have procured a Certificate of Authority to do so from the Rhode Island Secretary of State (401-222-3040). This is a requirement only of the successful vendor(s).

11. The vendor should be aware of the State's Minority Business Enterprise (MBE) requirements, which address the State's goal of ten percent (10%) participation by MBE's in all State procurements. For further information, contact the MBE Administrator at (401) 574-8253 or visit the website www.mbe.ri.gov or contact charles.newton@doa.ri.gov.

2. REQUEST FOR INFORMATION

This RFI outlines the type of information being solicited from potential respondents and includes guidelines for content and format of responses.

2.1 REQUIREMENTS AND DEADLINES FOR QUESTIONS AND RESPONSES

2.1.1 QUESTIONS

Questions concerning this RFI may be e-mailed to the Division of Purchases at David.Francis@purchasing.ri.gov no later than the date and time indicated on page one of this RFI. Please reference RFI # 7477366 on all correspondence. Questions should be submitted in a Microsoft Word attachment. Answers to questions received, if any, will be posted on the Internet as an addendum to this RFI. It is the responsibility of all interested parties to download this information. If technical assistance is required to download, call the Help Desk at (401) 574-9709.

Offerors are encouraged to submit written questions to the Division of Purchases. **No other contact with State parties regarding this RFI should be attempted**. Responses to this RFI should be submitted on or before the date listed on the cover page.. Responses received after this date and time, as registered by the official time clock in the reception area of the Division of Purchases may not be considered.

2.1.2 RESPONSES

Submit one (1) original and two (2) copies, and one electronic copy of responses by the date and time stated on page one of this RFI. Submissions should be single spaced on 8 ½" by 11" pages with 1" margins using Times Roman 12 font.

Responses (an original plus two (2) copies/one electronic copy) must be mailed or hand-delivered in a sealed envelope marked "**RFI# 7477366 Emergency Room Diversion**" to:

RI Department of Administration
Division of Purchases, 2nd floor
One Capitol Hill
Providence, RI 02908-5855

NOTE: Responses received after the above-referenced due date and time may not be considered. Responses misdirected to other State locations or those not presented to the Division of Purchases by the scheduled due date and time may be determined to be late and may not be considered.

Responses faxed, or emailed, to the Division of Purchases may not be considered. The official time clock is in the reception area of the Division of Purchases.

Based on the responses, Rhode Island may invite a vendor to present their approach and demonstrate their technical solution.

2.2 INTRODUCTION

The Rhode Island Division of Purchases ("Division"), on behalf of the State of Rhode Island ("State", "Rhode Island", or "RI"), is issuing this Request for Information ("RFI") to solicit specific information about a Sobering Treatment Opportunity Program (*STOP*).

2.3 PURPOSE OF THIS REQUEST FOR INFORMATION

In the 2012 legislative session, the General Assembly approved legislation[1] to make the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) responsible for presenting a proposal for a three-year pilot program to divert individuals impaired by substance abuse related issues to an alternative treatment program outside of the hospital emergency department. The Department of Health will collaborate with the municipality involved to coordinate and develop transportation options for these individuals to the pilot program. Once approved by the Governor and the General Assembly, and adequately funded, this pilot program will begin to serve as a resource for emergency transport and hospital EDs to better serve this target population. This Request for information includes a detailed description of a program developed by BHDDH including the facility and services needed to develop and implement a Sobering Treatment Opportunity Program (*STOP*), serving the City of Providence, in response to this situation. However, potential implementers of the program may have additional ideas about what the program should look like. This RFI seeks to gather that information.

[1] Senate Bill 2561 Substitute A

2.4 BACKGROUND

In Providence, and throughout the State, there has been a historic overreliance on municipal emergency transport vehicles and hospital emergency rooms as a source of treatment for individuals with non-emergency conditions and behavioral health issues. Current regulations require that emergency patients be transported by licensed ambulances staffed by licensed EMTs to a hospital, including those patients who happen to be intoxicated and collapsed in a public area. This practice is considered both wasteful and an inappropriate use of a high level of emergency transportation and medical care for non-emergency situations. This is currently occurring at a time when municipalities and hospitals have diminishing resources to appropriately serve the public.

With so many inappropriate non-emergency runs, the municipalities are seeking ways to effectively address this issue to make available more emergency transport capacity for true emergencies without frequently calling other cities and towns for back-up, and to achieve savings. In addition, hospital emergency departments seek to reduce overcrowding from non-emergency cases, in part, by supporting a system whereby individuals who are suffering from severe intoxication could be managed at a more suitable location, where they could be encouraged to seek appropriate follow-up treatment and have better coordinated access to other community-based resources and supports.

In 2010, the RI General Assembly created the Special Senate Commission to Study Cost Containment, Efficiency and Transparency in the Delivery of Quality Patient Care and Access by Hospitals. Included in this Commission's work was the recommendation that specified a need to create more behavioral health interventions. As a result of this recommendation, the RI Senate passed S875, creating a Special Commission to Study Emergency Department Diversion, which gathered experts in the substance abuse field, ED staff, department directors, medical professionals, provider CEOs, insurance providers and first responders, who examined current research and data of non emergent ED usage, alternatives and opportunities.

Inherent in the study were universal themes, which identified:

- The current system's failure to appropriately and cost effectively transport and treat individuals with non emergent behavioral health issues;
- The devastating impact to both the individual and the system when budget cuts undermine service provision; and
- The importance of examining and changing laws that prevent alternatives to screening and treating non emergent behavioral health issues in locations other than the hospital emergency departments.

Utilization of the hospital emergency department services for individuals with chronic alcohol dependence for non emergent medical needs is not only a system failure but also a medical care failure for the individual. Better alternatives and more effective approaches can be utilized with a commitment to changing our current system of care. This includes developing an alternative approach of delivering supportive, comprehensive services that provide a continuum of care for

chronic alcohol-dependent individuals and are proven to reduce re-admissions and move individuals toward meaningful treatment and recovery.

The findings of the Special Senate Commission have led to the recommendation of the establishment of a Sobering Treatment Opportunity Program (*STOP*) program.

The Special Senate Commission Findings:

- Emergency departments currently face an over utilization of high cost, high levels of non emergent behavioral healthcare usage that could be appropriately treated in alternative settings;
- Municipalities face significant costs and personnel stressors for transporting individuals with non urgent behavioral health and /or substance use disorders to emergency room departments;
- Patients and providers face significant treatment access issues: patient obstacles and third party limitations, budget and resource limitations;
- Our state system currently provides funding for alternative stabilization units for those diagnosed with psychiatric disorders but limits eligibility criteria through regulations, significantly reducing access to those with active substance use disorders in need of services;
- Current Department of Health state Ambulance Advisory Council protocols for individuals with behavioral health and/or substance use disorders prevent Emergency Medical Technicians from transporting individuals to settings other than a hospital emergency department;
- Coordination among health care providers and the delivery system is fragmented for individuals with behavioral health and/or substance use disorders, lacking a continuum of comprehensive, integrated emergency services; and
- Nationally, there are demonstrated models that provide quality care for individuals with behavioral health and/or substance use disorders outside of hospital emergency departments that document improved health outcomes.

The Senate Commission made the following Recommendations to address the inappropriate transportation to, and utilization of, hospital emergency departments for chronic alcohol dependent individuals who are intoxicated without emergent medical conditions:

1. Amend existing RI alcohol statue to make it more flexible.
2. Create state-wide care partnerships to enhance patient-centered systems of care to include on-demand services, 24-hour triage center programs, mobile outreach transportation teams, and telephone triage system for substance use disorders/behavioral health issues.
3. Support opportunities through Health Homes Medicaid enhanced funding to include on-demand, substance use and/or behavioral healthcare and transitions to community supports.

4. Pilot program with evidence based, suicide/mental health assessment tools and training for first responders, healthcare professionals to determine appropriate placement in ER or diversion program.
5. Support the development of a pilot program with protocols for Emergency Medical Services (EMS) transports to alternative facilities. The Department of Health is ultimately responsible for this aspect of the program, However, responders to this RFI should describe what they could provide in terms of transport.
6. Support opportunities to enhance or reinvest savings for best practice housing models that include supportive services and employment/training linkages.
7. Support the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals in exploring opportunities for funding the alternative program.

2.5 PROJECT OVERVIEW

The proposed three-year pilot program conceived by BHDDH, suggested to be called the "Sobering Treatment Opportunity Program" or "STOP," would be initially developed to serve individuals, 18 years of age or older, in the City of Providence. Overseen by BHDDH and managed by a successful bidder, the STOP program would be a collaborative effort of the Fire and Police Departments of the City; RI Hospital and the Emergency Medicine physicians who staff the Emergency Department of the hospital; the Department of Health EMS Services; existing substance abuse and behavioral healthcare agencies that provide detoxification, treatment, care coordination and support services; homeless service providers who provide a range of transitional housing options for individuals struggling with substance abuse and in various stages of recovery; and the organizations that develop employment opportunities for recovering individuals. Statutes that affect transportation, approved facilities and mandatory treatment of this population will need to be addressed as part of the *STOP* program implementation.

RI General Laws

Certain statutes and regulations in RI that regulate emergency transport, hospital emergency rooms, treatment of alcoholics, mandated treatment, etc., will need to be reviewed and addressed relative to this program. Emergency room physicians who have traditionally treated these individuals will need to be oriented on the revised and/or newly enforced statutes to facilitate the use of the alternative treatment program and emergency commitments, as appropriate.

RI General Laws 23-1.10-10: Treatment and services of intoxicated persons and persons incapacitated by alcohol- requires that intoxicated persons be brought to an approved treatment facility for emergency treatment (affiliated with or part of the medical services of a hospital)… and shall be examined by a licensed physician as soon as possible. The facility planned for this pilot program would need to qualify as an approved treatment facility for persons to be transported to, outside of a hospital emergency department, and staffed by qualified individuals other than exclusively licensed physicians, who can monitor the residents and help them move through the continuum of care towards recovery.

RIGL Chapter 23, Section 23-1.10-11: Emergency commitment- establishes a process for Emergency Commitment for intoxicated persons, which can be utilized for:.. "(1) an intoxicated person who has threatened, attempted, or inflicted physical harm on himself or herself or another and is likely to inflict physical harm on himself or herself or another unless committed, or (2) is incapacitated by alcohol"… As per the statute, a certifying physician, spouse, guardian, relative or any other responsible person can make a written application for commitment to the administrator of the approved facility for not more than ten (10) days. The Department, with the assistance of appropriate clinical providers, will develop the standards for consideration and review for these commitment requests. This existing statute, although potentially helpful for some of the current chronic alcoholic population, has not been used, primarily because there is no "approved public treatment facility for emergency treatment", as per the statute, that can provide a secured treatment environment. The proposed program would need to be designed to fulfill that status. The program would need to be able to secure those individuals who fall into the committed category and still have the flexibility to serve those who do not warrant mandated treatment.

RIGL Chapter 23, Section 23-1.10-12: Involuntary commitment of alcoholics- establishes a process for longer term Involuntary Commitment of Alcoholics. This process, which involves a petition to the district court, can be utilized for those individuals who have the same risks of danger to themselves or others as described in the Emergency Commitment statute, along with the risk of continuing to suffer abnormal mental, emotional or physical distress, continuing to deteriorate in ability to function independently if not treated, and inability to make a rational and informed choice as to whether or not to submit to treatment. This commitment can continue for a stated period of time as long as the likelihood of harm to him/her self or others continues to exist. The Department will evaluate the appropriateness of increased use of this statute after a period of evaluation of the experience of the program.

Entities responding to this RFI should indicate how they would make use of these laws, and indicate what changes, if any, they would recommend to altering these laws.

Transportation and Screening

Arrangements for transportation to the *STOP* program will need to be coordinated and developed with the municipality and the Department of Health. This can be accomplished by establishing and funding a community-based, homeless outreach response team. A transport van service, which is not an ambulance, will need to be created or outsourced, manned with a licensed Emergency Medical Technician and a homeless outreach worker. Currently, private and public ambulance services are licensed through the Department of Health. The proposed vehicle for this pilot program will not be an ambulance, as it will not contain all of the ambulance equipment required for health emergencies and it will not have the minimum staffing required for an ambulance service. Therefore, this transport service, designed similar to those in programs in other states, will not require ambulance licensure.

This transport service should be fully operative seven days per week from early morning to late evening and, particularly responsive during the stated peak hours of 10:00 AM- 2:00 PM, when EMS transport has frequently been called to transport this population to the hospital. The team will need to routinely travel to known areas where alcohol dependant individuals have historically been transported (i.e. the 300 block of Broad Street, Kennedy Plaza and Chalkstone Avenue in Providence, etc.), to homeless shelters, as well as to respond to calls reporting inebriated individuals anywhere in the City who need assistance. In their travels, the *STOP* team will also work proactively to engage individuals to come to the Program before they are so inebriated that it would only be safe to take them to the ER. Arrangements need to be made so that police dispatch and local officers will have a direct communication link to the *STOP* outreach team, to facilitate a coordinated EMS transport to calls where intoxicated individuals may have medical, trauma or behavioral healthcare issues likely requiring emergency department services and/or hospitalization.

When called, the team will screen individuals for health issues beyond alcohol or substance abuse and, if appropriate and permissible based on established clinical protocols, transport the individuals to the *STOP* program instead of hospital EDs. As part of the screening, the team will be directed to utilize general criteria based on a pilot study of EMTs' field assessment of intoxicated patients' need for ED care.[2] The study indicated that the answer to all of the listed questions about the individual should be "No" to be considered appropriate for the STOP program alternative to the ED:

- Complaint other than alcohol intoxication?
- Age younger than 18 years?
- Abnormal vital signs (as defined in the protocols)?
- Abnormal pulse oximetry?
- Any sign of trauma?
- Any sign of illness?
- Any sign of environmental emergency?
- Abnormal blood sugar (as defined in the protocols)?
- Aggressive/confrontational?
- Other findings of concern?

As experience with the program and patients builds, some of the criteria may be modified through coordination with the hospital physician staff, based on the capacity of the STOP program and treatment staff.

Program Values and Services

Individuals who are caught in a cycle of inebriation and hospitalization need four critical supports to help them recover from this cycle and move towards leading productive and fulfilling lives:

[2] Cornwall AH, Zaller N, Warren O, et al. A pilot study of emergency medical technicians' field assessment of intoxicated patients' need for ED care. The American journal of emergency medicine. 2012;30(7):1224–8. Available at: http://www.ncbi.nlm.nih.gov/pubmed/22056060

- Medical stabilization and access to integrated healthcare services, including quick access to detoxification services and treatment services that are highly effective in engaging people who are often alienated from mainstream systems.
- Direct access to transitional housing, which supports lifestyle change until they can access residential treatment and, eventually, permanent housing.
- The development of peer relationships that nurture and support personal transformation and recovery in a respectful environment.
- Attainment of income through employment or accessing benefits which will often require assisting clients to obtain "proofs" or legal documentation.[3]

Additionally, programmatic and treatment values should be established as the foundation of the *STOP* program. Safety of the clients and staff should be a priority. Clients should be treated with respect and dignity and not encounter the social stigma that occurs with these conditions. Prevention and early intervention should be utilized as often as possible. Treatment settings should be the right services at the right time in the most cost effective and accountable manner, leading to positive outcomes. Harm reduction and motivational counseling should be utilized to encourage clients to agree to participate and continue in treatment and recovery services. Care coordination and transition assistance should be provided throughout the client's involvement in the program.

It is recommended that the ED Physician's group at RI Hospital and medical interns and residents from Brown University Medical School be engaged to provide medical support and staff for daily rounds and ongoing coordination at the facility to monitor medical issues, prescribe medications, perform minor primary care services, and facilitate transfer to the hospital, whenever necessary.

As communicated to the Department by the ED Physicians Group, presence of any of the following signs or symptoms of the impaired individual will be grounds for immediate transport to the hospital ED and should be incorporated into the applicant's profile of services:

- Complaints in addition to alcohol intoxication
    - Head Trauma
    - Significant other trauma
    - Chest pain
    - Acute abdominal pain (does not include chronic daily abdominal pain)
    - Hematemasis (bloody vomit)
    - Suicidality or Homocidality
    - Belligerent or threatening behavior
- Abnormal vital signs
    - Systolic blood pressure >180 or <90
    - Pulse >115 or <50
    - Oxygen saturation <92%
    - Temperature >99.9 F or < 97.0 F

[3] Food stamps, SSI, SSDI and Medicaid/Medicare require clients to have proof of RI residence, original birth certificate, photo ID, and a social security card.

    - Blood glucose <75mg/dL (if able to drink juice) or <80 mg/dL if unable to drink juice or >200 (without a history of diabetes) or >300 (with a history of diabetes)
- Abnormal physical exam findings
    - New trauma to the head or face
    - Cervical spine midline tenderness
    - Laceration requiring suture closure
    - Significant abdominal tenderness to palpation
    - GCS <13 (This will exclude patients with excessive somnolence)
    - Focal neurologic findings (i.e., new weakness)
    - CIWA (alcohol withdrawal score) >10 [2]

For individuals without serious medical conditions that require a hospital setting, community-based detoxification with affiliated services would be appropriate. Peer specialists/recovery coaches should be utilized to help engage clients to consider treatment and guide them through the steps of participation, recovery and ongoing support services in the program. It is important that clients feel cared for and engaged in their care. However, the question of enabling unhealthy behavior is also a concern. A number of these clients have regularly refused ongoing treatment and support. Voluntary engagement in treatment is always preferred; therefore, policies must be developed to create incentives to get individuals to make use of the service opportunities that are available through the *STOP* program. Some examples of incentivizing policies would be to require individuals, who go to the program three or four times in a four-day period, for example, to sign a pledge to participate in treatment and support the next time they need help. Vouchers for food, clothing, housing, etc., have also been effective. The judicial system has a history of recommending treatment for individuals involved in the criminal justice system as a part of their judgments. While these clients are typically involved in misdemeanor level infractions that call them to the attention of the police (public nuisance, disorderly conduct, etc.), there is still a precedent for recommending treatment as part of one's plea.

Although voluntary engagement into the treatment and recovery program is always the preferred method, most clinicians and many clients consulted leading to the recommendations for this project, have indicated that mandatory treatment may be the most effective way to engage certain clients who have not been sober for a lengthy period of time. Due to excessive alcohol use and dependence, these individuals may have incurred a serious impact on brain functioning and the associated behaviors related to brain impairment. Thus, these clients would need to maintain sobriety for a significant period of time to be able to understand what it would be like to be sober and to regain better brain, behavioral and physical functioning. To that end, mandatory treatment would be warranted. As per the identified statutes, this would be appropriate for individuals who are deemed to be a danger to themselves or others because of their potential of becoming inebriated again and dying from alcohol poisoning, hypothermia, head or other trauma from falling or accidents, or from driving under the influence. Typically, these clients may be out of immediate danger when they achieve reduced inebriation, but if they are released to continuously engage in the same addictive behavior, they are once again a danger to themselves and society. Therefore, there is a rationale for the option to mandate treatment.

Housing, employment and ongoing support benefits are the critical components of achieving and maintaining sobriety and fostering meaningful recovery. Since most of the frequent, chronically alcohol-dependent individual utilizers of the emergency department services are homeless, in order to reap the benefits of the services described, housing must be part of the equation. It is recommended that operating subsidies and rental vouchers be created for this population, enabling affordable housing projects and market rate landlords to assist lower income individuals (including the homeless and disabled). Types of services available in the community, which need to be addressed and coordinated, that would be helpful to this population include, but are not limited to, the following:

Housing:

- Housing location programs
- Housing First and other community-based housing programs
- Section 8, Rhode Home, Shelter Plus Care
- Rental classes and other educational programs on successful housing retention
- Veteran's Housing Assistance programs
- Veteran's community outreach and housing programs
- Public Housing Authorities

Employment:

- Employment First model of assisting individuals with employment
- State employment support agencies and programs like ORS, Ticket to Work and DLT
- Community-based training and employment programs
- Community-based placement programs
- Integration with Governor's plans to increase employment in the State

Benefits:

- SSI/SSDI Outreach, Access and Recovery (SOAR)
- Benefits Specialists (from CMHOs)
- Veteran's Benefits Administration
- The Point/Options Counseling and other programs through Medicaid/Medicare

Physical Space

The *STOP* program will need to have adequate physical space where individuals can safely go to achieve short-term sobriety or safe reduction in inebriation and be engaged by peers and substance abuse treatment providers. The capacity of the initial clinical observation phase of the *STOP* program, based on the volume of chronic alcoholic clients projected from emergency transports and emergency department admissions of chronic alcoholic individuals, is recommended to be appropriately staffed to accommodate 15 individuals for a period of approximately 24-48 hours. The program will need to be operational 24/7 and have the capacity in house or connections to medical detoxification for those that need it and are willing to

participate. Full time security will be necessary to ensure the safety of clients and staff, particularly if they are mandated to treatment. It would be helpful to have a kitchen where food can be prepared and fluids can be stored to help clients regain sobriety.

The space should be designed to include a separate area for congregate and private meeting rooms for group and private engagements with care coordinators, peers and treatment providers and to encourage provision of detoxification services. This area can also be used by professionals who could help clients with substance abuse treatment, relapse prevention, coping skills, employment, housing, benefits, education, exercise, family re-integration and general skill building during the day. By making this type of environment available to other homeless individuals, or those at risk of homelessness who have employment, training and educational needs, blended funding and collaboration could be promoted with the Office of Housing and Community Development and community-based providers of these services.

Preferably, the site used for the *STOP* program will have, or be connected to, a diverse set of day program opportunities that can serve as an alternative to consuming alcohol, and help break the daily cycle of chronic inebriation and required acute recovery services. Blending funding and sharing space with homeless service providers seeking to provide day programs, intake, assessment and referrals for their clientele to community based services, would also create service coordination and financial efficiencies. If the space is large enough to accommodate a health clinic, further safety and wellness could be facilitated with clients.

Transitional Housing Capacity

Since housing is such a critical factor in maintaining treatment gains and assisting in recovery, a second separate area with a capacity for 15-20 individuals should be created, in-house or outsourced, to provide transitional housing for 20-30 days to individuals who have "graduated" into sobriety and could benefit from this level of community service and support. After which, other housing options, such as permanent, supportive, subsidized or mainstream housing can be arranged. This is also important for engaging individuals to pursue treatment, because the existing transitional housing capacity in the state is not sufficient for immediate placement. Some residential treatment programs require 30 days of sobriety before admission, or have wait times before entry due to being filled to capacity. Recovery Houses/sober houses often require 30 days of sobriety before admission. The transitional housing component of the Program can provide housing until such time that the client can access residential treatment, or if appropriate, recovery housing. By co-locating these services, financial efficiencies for staffing and space can be maximized and an individual needs-based and responsive system of care can be provided.

Data Collection

Currently, RI Hospital is collecting data (mostly demographic, utilization and insurance, etc.) on this population. The Department will ask the vendor to collect this demographic, utilization and insurance data as well, along with data that reports source of referral to the program, and referrals made from the program; summaries of clinical findings on assessment and care coordination; housing, employment and veteran status; outcome measures and follow-up care

with tracking of sobriety, treatment, housing and employment status 30, 90 and 180 days out of the program. The Department will also work with the vendor to determine actual costs, and cost savings (deferred costs, etc.) of this program and other categories to present in its annual report to the General Assembly and Governor.

Current System of Care

Respondents should be aware of current addiction treatment capabilities and services in place in Rhode Island, to coordinate and collaborate in the development, implementation and ongoing operation of the *STOP* program, and to encourage individuals to seek treatment for their addiction. BHDDH has a full continuum of addiction treatment services related to alcohol, drug and prescription medication misuse and abuse available to those in need. Funding for addictions treatment is provided through the federal Substance Abuse Prevention Treatment Block Grant (SAPTBG) Block Grant, state general revenue dollars, Medicaid and other federal grants such as the Access to Recovery Program. As of January 1, 2014 a whole new population of single adults will become eligible for Medicaid as part of the expansion population. Their eligibility will be based solely on income, or lack thereof. It is anticipated that most of the clients to be served by the *STOP* program will be part of this expansion population and the program costs will be substantially reduced through the use of the expanded funding by assisting clients to apply for benefits through the Medicaid portal.

Addiction treatment programs include inpatient detoxification services, outpatient detoxification, and detoxification step-down beds, which provide an opportunity for continued stabilization while an individual prepares for reintegration into the community or a residential treatment setting. The General Outpatient Program (GOP) for the indigent and uninsured provides drug-free outpatient services for alcohol, drug dependent and addicted persons. The GOP works with five prime contractors - organizing services in their respective service areas which encompass general outpatient, intensive outpatient and partial hospitalization levels of care. New contracts require these providers to establish strong linkages with recovery support service providers in their communities including recovery coaching through peers. BHDDH also funds residential treatment services for adults and adolescents.

The BHDDH funded residential treatment system ranges from transitional programs with a 7-14 day length of stay to short-term residential (30 – 90 days) to long-term care programs of up to 180 days, and includes working half-way houses. Five of the adult residential providers are now women-only facilities, and include a program where children are able to stay with their mothers while they are in treatment. This new system actually decreased the total number of treatment beds available, but has an expectation to increase the number of unique individuals served through more effective level of care transitioning, and the incorporation of recovery oriented services which includes newly funded recovery houses.

BHDDH functions as the federally-mandated State Opioid Treatment Authority. The Department provides funding for the uninsured in eight of the twelve authorized OTP programs. It is

anticipated that use of heroin and synthetic opioids will continue to be a significant issue in the State of Rhode Island. Because of this, funded treatment slots will continue to be filled beyond capacity. These slots are supported by the use of costs not otherwise matchable (CNOMS) through the Medicaid 115 Waiver.

The 2013 BHDDH budget proposal calls for the creation of Medicaid-supported Health Homes for Medicaid-funded opioid treatment clients. This initiative is designed to provide stronger linkages between opioid treatment providers and the patients' medical service delivery systems; assign primary responsibility for the oversight of health care and wellness promotion to the Health Home team of the OTP; improve transitions between levels of care; improve access to necessary healthcare services; address chronic disease self management needs, and; provide support and education to patients and their families. Concepts from this program can be utilized by the *STOP* program for its population. The program would benefit from having access to an electronic health records (EHR) system to foster real-time communication between treatment providers at the various stages of the continuum.

A primary focus for BHDDH addiction treatment system is the incorporation of recovery principles into its service delivery system. Recovery-oriented systems support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families and communities, encouraging them to take responsibility for their sustained health, wellness and recovery. BHDDH's movement in this area has been guided by the recommendations of the Governor's Council on Behavioral Healthcare, Recovery Oriented System of Care Committee. Development and enhancement of a recovery-oriented system of care (ROSC) has been furthered by the recent receipt of three grants: the Access to Recovery (ATR), the Transformation Transfer Initiative (TTI) and the Employment Development Initiative (EDI). In September of 2007, and again in September 2010, the Department was awarded the ATR grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The ATR program allows clients to choose among substance abuse clinical treatment and recovery support service providers, expands access to a comprehensive array of clinical treatment and recovery support options (including faith-based programmatic options), and increases substance abuse treatment capacity. Since 2007, the Rhode Island ATR has served over 2,600 clients, providing clinical treatment and recovery support services resulting in positive, measureable outcomes. The ATR program has resulted in significant improvements in abstinence rates and decrease in arrest (or re-arrest) rates, 5 to 7 months post-admission. Both the TTI and the EDI involved the training and placement of peers to provide support for individuals with mental health disorders. These programs have been very successful at supporting Health Home services and employment initiatives at clubhouses and recovery centers.

The Department continues to implement the Transition from Prison to Community Program. This program provides residential or intensive outpatient substance abuse treatment services to parolees for whom these services are a required condition of parole. This funding has increased capacity at residential treatment programs and allowed inmates, who were previously waiting in prison for a state-funded residential bed to become available, to have quicker access to treatment.

All referred parolees receive a standardized assessment by a Licensed Chemical Dependency Professional and are then referred to the appropriate clinical setting. Additional funding for this initiative was obtained through Byrne/Jag and contracted through The Providence Center. These funds increased the overall residential beds available for this program and provided recovery support services following successful completion of treatment. While the residential portion of Byrne/Jag funding has been exhausted, the Department continues to support recovery services for this population.

Prevention services are provided through 35 contracts with municipalities funded through the Rhode Island Substance Abuse Prevention Act. Through these programs, residents of all of the state's 39 municipalities are exposed to public education and other strategies designed to change community norms, prevent alcohol and other drug use, reduce retail purchases of alcohol by children and youth, and arrest the progression from initial substance use to abuse and dependency.

3. CONTENT OF RESPONSE

The following information is intended to minimize the effort of the respondent and structure the response for ease of analysis. The listed questions can be used to guide responses; please note that an answer to each question is not required. Concise responses are appreciated.

1. BHDDH is interested in obtaining an understanding of the interest of respondents to implement this program as well as potential respondents' ideas about how the program should look. The state would benefit from interested parties that submit a plan for implementation that includes a proposed budget, project location(s), and staffing pattern as well as suggestions for modifying or improving the program. In describing the project location(s) respondents should indicate whether they have secured the property, would need to secure the property or would be requesting a state-owned property. If it is a state-owned property, the respondent should indicate which property they are asking to use.

2. BHDDH is also interested in obtaining an understanding of how respondents perceive the laws that mandate treatment and how they would utilize them if they were to implement the program.

3. BHDDH would benefit from understanding how respondents would make use of unpaid staff such as the ED Physician's group at RI Hospital and medical interns and residents from Brown University Medical School.

4. Respondents are encouraged to suggest alternative models to the BHDDH-developed *STOP* program and/or identify any critical components that have not been addressed. They are also encouraged to describe how they would implement the transportation portion of the program.

5. Respondents are encouraged to propose how they would coordinate or integrate the provision of detoxification services into the *STOP* program.

6. Respondents are encouraged to present how they would coordinate and integrate existing substance abuse treatment services into the *STOP* program.

7. Respondents are encouraged to present strategies and processes to access housing, employment and other benefits/services that would serve to help preserve treatment gains.

8. Respondents are welcome to offer information on all or only part of the program that they would be interested in implementing.

Disclaimer

This Request for Information is solely for information and planning purposes and does not constitute a Request for Proposal. All information received in response to the RFI and marked as "Proprietary" will be handled accordingly. Responses to the RFI cannot be accepted by the State to form a binding contract. Responses to the RFI will not be returned. Respondents are solely responsible for all expenses associated with replying to this RFI.

END